R590. Insurance, Administration. (*Effective 12-8-2011*)
R590-261. Health Benefit Plan Adverse Benefit Determinations.
R590-261-1. Authority.

This rule is promulgated pursuant to Subsection 31A-22-629(4) which requires the commissioner to adopt rules that establish standards for independent reviews, Subsection 31A-2-201(3)(a) wherein the commissioner may make rules to implement the provisions of Title 31A and 31A-2-212(5)(b) wherein the commissioner requires compliance with the Patient Protection and Affordable Care Act.

R590-261-2. Purpose.

The purpose of this rule is to provide a uniform standard for the establishment and maintenance of an independent review procedure to assure that a claimant has the opportunity for an independent review of a final adverse benefit determination.

R590-261-3. Scope.

(1) Except as provided in Subsection (2), this rule applies to all health benefit plans as defined in 31A-1-301 except for a grandfathered health plan as defined in 45 CFR 147.140.

(2) If all grandfathered health benefit plans are administered consistently, a carrier may, for the grandfathered health benefit plans, voluntarily comply with the independent review process set forth in this rule, otherwise a grandfathered health benefit plan is subject to R590-203.

(3) A self-funded health plan may voluntarily comply with the independent review process set forth in this rule.

R590-261-4. Definitions.

In addition to the definitions in Section 31A-1-301, the following definitions apply for purposes of this rule:

(1)(a) "Adverse benefit determination" means:

(i) based on the carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, the:

(A) denial of a benefit;

(B) reduction of a benefit;

(C) termination of a benefit; or

(D) failure to provide or make payment, in whole or part, for a benefit; or

(ii) rescission of coverage.

(b) "Adverse benefit determination" includes:

(i) denial, reduction, termination, or failure to provide or make payment that is based on a determination of an insured's eligibility to participate in a health benefit plan;

(ii) failure to provide or make payment, in whole or part, for a benefit resulting from the application of a utilization review; and

(iii) failure to cover an item or service for which benefits are otherwise provided because it is determined to be:

(A) experimental;

(B) investigational; or

(C) not medically necessary or appropriate.

(2) "Carrier" means any person or entity that provides health insurance in this state including:

(a) an insurance company;

(b) a prepaid hospital or medical care plan;

(c) a health maintenance organization;

(d) a multiple employer welfare arrangement; and

(e) any other person or entity providing a health insurance plan under Title 31A.

(3) "Claimant" means an insured or legal representative of the insured, including a member of the insured's immediate family designated by the insured, making a claim under a policy.

(4) "Clinical reviewer" means a physician or other appropriate health care provider who:

(a) is an expert in the treatment of the insured's medical condition that is the subject of the review

(b) is knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating patients with the same or similar medical condition;

(c) holds an appropriate license or certification; and

(d) has no history of disciplinary actions or sanctions.

(5) "Final adverse benefit determination" means an adverse benefit determination that has been upheld by a carrier at the completion of the carrier's internal review process.

(6) "Independent review" means a process that:

(a) is a voluntary option for the resolution of a final adverse benefit determination;

(b) is conducted at the discretion of the claimant;

(c) is conducted by an independent review organization designated by the commissioner;

(d) renders an independent and impartial decision on a~~n~~ final adverse benefit determination; and

(e) may not require the claimant to pay a fee for requesting the independent review.

(~~6~~7)(a) "Rescission" means a cancellation or discontinuance of coverage under a health benefit plan that has a retroactive effect.

(b) "Rescission" does not include a cancellation or discontinuance of coverage under a health benefit plan if the cancellation or discontinuance of coverage:

(i) has only a prospective effect; or

(ii) is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

R590-261-5. Adverse Benefit Determination Procedure Compliance.

An adverse benefit determination procedure shall be compliant with this rule and the requirements for adverse benefit determinations set forth in 29 CFR 2560.503-1 and 45 CFR 147.136.

R590-261-6. Notice of Right to Independent Review.

(1) With each notice of a rescission of coverage or final ~~an~~ adverse benefit determination, the carrier shall provide written notice of the claimant's right for an independent review of the determination.

(2) The notice in Subsection (1) shall include the following, or substantially equivalent, statement:

"We have rescinded your coverage or denied your request for the provision of or payment for a health care service or course of treatment. You may have the right to have our decision reviewed by a health care professional who has no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested. To receive additional information about an independent review, contact the Utah Insurance Commissioner by mail at Suite 3110 State Office Building, Salt Lake City UT 84114; by phone at 801 538-3077; or electronically at healthappeals.uid@utah.gov."

R590-261-7. Exhaustion of Internal Review Process.

The carrier's internal review process shall be exhausted prior to an independent review unless:

(1) the carrier agrees to waive the internal review process;

(2) the carrier has not complied with the requirements for the carrier's internal review process except for those failures to comply that are based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the claimant and are not part of a pattern or practice of violations; or

(3) the claimant has requested an expedited independent review pursuant to Section 11 at the same time as requesting an expedited internal review.

R590-261-8. Independent Review Organizations.

(1) The commissioner shall compile and maintain a list of approved independent review organizations.

(2) To be considered for placement on the list of approved independent review organizations, an independent review organization shall:

(a) be accredited by a nationally recognized private accrediting entity;

(b) meet the requirements of this rule; and

(c) have written policies and procedures that ensure:

(i) that all reviews are conducted within the specified time frames;

(ii) the selection of qualified and impartial clinical reviewers;

(iii) the confidentiality of medical and treatment records and clinical review criteria; and

(iv) that any person employed by or under contract with the independent review organization adheres to the requirements of this rule.

(3) An applicant requesting placement on the list of approved independent review organizations shall submit for the commissioner's review:

(a) the Independent Review Organization Application form available on our website at www.insurance.utah.gov;

(b) all documentation and information requested on the application, including proof of being accredited by a nationally recognized private accrediting entity; and

(c) the application fee.

(4) The commissioner shall terminate the approval of an independent review organization if the commissioner determines that the independent review organization has lost its accreditation or no longer satisfies the minimum requirements for approval.

(5)(a) An independent review organization may not own or control, or be owned or controlled by:

(i) a carrier;

(ii) a health benefit plan;

(iii) a health benefit plan's fiduciary;

(iv) an employer or sponsor of a health benefit plan;

(v) a trade association of:

(A) health benefit plans;

(B) carriers; or

(C) health care providers; or

(vi) an employee or agent of any one listed in Subsection (5)(a)(i) through (v).

(b) An independent review organization and the clinical reviewer assigned to conduct an independent review may not have a material professional, familial, or financial conflict of interest with:

(i) the carrier;

(ii) an officer, director, or management employee of the carrier;

(iii) the health benefit plan;

(iv) the plan administrator, plan fiduciaries, or plan employees;

(v) the insured or claimant;

(vi) the insured's health care provider;

(vii) the health care provider's medical group or independent practice association;

(viii) a health care facility where the service would be provided; or

(ix) the developer or manufacturer of the service that would be provided.

R590-261-9. General Independent Review Requirements.

The requirements of this section shall apply in addition to the requirements for a standard independent review, an expedited independent review and an independent review of experimental or investigational service or treatment.

(1) The carrier shall pay the cost of the independent review organization for conducting the independent review.

(2) An independent review is available to the claimant regardless of the dollar amount of the claim involved.

(3)(a) The claimant shall have 180 calendar days after the receipt of a notice of a final adverse benefit determination to file a request with the commissioner for an independent review.

(b) The claimant shall use the Independent Review Request Form available on our website at www.insurance.utah.gov, or a substantially similar form, to file the request.

(c) A request for an independent review sent to the carrier instead of the commissioner shall be forwarded to the commissioner by the carrier within one business day of receipt.

(4) The independent review decision is binding on the carrier and claimant except to the extent that other remedies are available under federal or state law.

R590-261-10. Standard Independent Review.

(1)(a) Upon receipt of a request for an independent review, the commissioner shall send a copy of the request to the carrier for an eligibility review.

(b) Within five business days following receipt of the copy of the request, the carrier shall determine whether:

(i) the individual is or was an insured in the health benefit plan at the time of rescission or the health care service was requested or provided;

(ii) if a health care service is the subject of the adverse benefit determination, the health care service is a covered expense;

(iii) the claimant has exhausted the carrier's internal review process; and

(iv) the claimant has provided all the information and forms required to process an independent review.

(c)(i) Within one business day after completion of the eligibility review, the carrier shall notify the commissioner and claimant in writing whether:

(A) the request is complete; and

(B) the request is eligible for independent review.

(ii) If the request:

(A) is not complete, the carrier shall inform the claimant and commissioner in writing what information or materials are needed to make the request complete; or

(B) is not eligible for independent review, the carrier shall:

(I) inform the claimant and commissioner in writing the reasons for ineligibility; and

(II) inform the claimant that the determination may be appealed to the commissioner.

(d)(i) The commissioner may determine that a request is eligible for independent review notwithstanding the carrier's initial determination that the request is ineligible and require that the request be referred for independent review.

(ii) In making the determination in (d)(i), the commissioner's decision shall be made in accordance with the terms of the insured's health benefit plan and shall be subject to all applicable provisions of this rule.

(2) Upon receipt of the carrier's determination that the request is eligible for an independent review, the commissioner shall:

(a) assign on a random basis an independent review organization from the list of approved independent review organizations based on the nature of the health care service that is the subject of the review;

(b) notify the carrier of the assignment and that the carrier shall within five business days provide to the assigned independent review organization the documents and any information considered in making the adverse benefit determination; and

(c) notify the claimant that the request has been accepted and that the claimant may submit additional information to the independent review organization within five business days of receipt of the commissioner's notification. The independent review organization shall forward to the carrier within one business day of receipt any information submitted by the claimant.

(3) Within 45 calendar days after receipt of the request for an independent review, the independent review organization shall provide written notice of its decision to uphold or reverse the adverse benefit determination to:

(a) the claimant;

(b) the carrier; and

(c) the commissioner.

(4) Within one business day of receipt of notice that an adverse benefit determination has been overturned, the carrier shall:

(a) approve the coverage that was the subject of the adverse benefit determination; and

(b) process any benefit that is due.

R590-261-11. Expedited Independent Review.

(1) An expedited independent review process shall be available if the adverse benefit determination:

(a) involves a medical condition of the insured which would seriously jeopardize the life or health of the insured or would jeopardize the insured's ability to regain maximum function;

(b) in the opinion of the insured's attending provider, would subject the insured to severe pain that cannot be adequately managed without the care or treatment that is the subject of the adverse benefit determination; or

(c) concerns an admission, availability of care, continued stay or health care service for which the insured received emergency services, but has not been discharged from a facility.

(2)(a) Upon receipt of a request for an expedited independent review, the commissioner shall immediately send a copy of the request to the carrier for an eligibility review.

(b) Immediately upon receipt of the request, the carrier shall determine whether:

(i) the individual is or was an insured in the health benefit plan at the time the health care service was requested or provided;

(ii) the health care service that is the subject of the adverse benefit determination is a covered expense; and

(iii) the claimant has provided all the information and forms required to process an expedited independent review.

(c)(i) The carrier shall immediately notify the commissioner and claimant whether:

(A) the request is complete; and

(B) the request is eligible for an expedited independent review.

(ii) If the request:

(A) is not complete, the carrier shall inform the claimant and commissioner in writing what information or materials are needed to make the request complete; or

(B) is not eligible for independent review, the carrier shall:

(I) inform the claimant and commissioner in writing the reasons for ineligibility; and

(II) inform the claimant that the determination may be appealed to the commissioner.

(d)(i) The commissioner may determine that a request is eligible for an expedited independent review notwithstanding the carrier's initial determination that the request is ineligible and shall require that the request be referred for an expedited independent review.

(ii) In making the determination in (d)(i), the commissioner's decision shall be made in accordance with the terms of the insured's health benefit plan and shall be subject to all applicable provisions of this rule.

(3) Upon receipt of the carrier's determination that the request is eligible for an independent review, the commissioner shall immediately:

(a) assign an independent review organization from the list of approved independent review organizations;

(b) notify the carrier of the assignment and that the carrier shall within one business day provide to the assigned independent review organization all documents and information considered in making the adverse benefit determination; and

(c) notify the claimant that the request has been accepted and that the claimant may within one business day submit additional information to the independent review organization. The independent review organization shall forward to the carrier within one business day of receipt any information submitted by the claimant.

(4)(a) The independent review organization shall as soon as possible, but no later than 72 hours after receipt of the request for an expedited independent review, make a decision to uphold or reverse the adverse benefit determination and shall notify:

(i) the carrier;

(ii) the claimant; and

(iii) the commissioner.

(b) If notice of the independent review organization's decision is not in writing, the independent review organization shall provide written confirmation of its decision within 48 hours after the date of the notification of the decision.

(5) Within one business day of receipt of notice that an adverse benefit determination has been overturned, the carrier shall:

(a) approve the coverage that was the subject of the adverse benefit determination; and

(b) process any benefit that is due.

R590-261-12. Independent Review of Experimental or Investigational Service or Treatment Adverse Benefit Determinations.

(1) A request for an independent review based on experimental or investigational service or treatment shall be submitted with certification from the insured's physician that:

(a) standard health care service or treatment has not been effective in improving the insured's condition;

(b) standard health care service or treatment is not medically appropriate for the insured; or

(c) there is no available standard health care service or treatment covered by the carrier that is more beneficial than the recommended or requested health care service or treatment.

(2)(a) Upon receipt of a request for an independent review involving experimental or investigational service or treatment, the commissioner shall send a copy of the request to the carrier for an eligibility review.

(b) Within five business days following receipt of the copy of the request, one business day for an expedited review, the carrier shall determine whether:

(i) the individual is or was an insured in the health benefit plan at the time the health care service was requested or provided;

(ii) the health care service or treatment that is the subject of the adverse benefit determination is a covered expense except for the carrier's determination that the service or treatment is experimental or investigational for a particular medical condition and is not explicitly listed as an excluded benefit under the insured's health benefit plan;

(iii) the claimant has exhausted the carrier's internal review process unless the request is for an expedited review; and

(iv) the claimant has provided all the information and forms required to process the independent review.

(c)(i) Within one business day after completion of the eligibility review, the carrier shall notify the commissioner and claimant in writing whether:

(A) the request is complete; and

(B) the request is eligible for independent review.

(ii) If the request:

(A) is not complete, the carrier shall inform the claimant and commissioner in writing what information or materials are needed to make the request complete; or

(B) is not eligible for independent review, the carrier shall:

(I) inform the claimant and commissioner in writing the reasons for ineligibility; and

(II) shall inform the claimant that the determination may be appealed to the commissioner.

(d)(i) The commissioner may determine that a request is eligible for independent review notwithstanding the carrier's initial determination that the request is ineligible and require that the request be referred for independent review.

(ii) In making the determination in (d)(i), the commissioner's decision shall be made in accordance with the terms of the health benefit plan and shall be subject to all applicable provisions of this rule.

(3) Upon receipt of the carrier's determination that the request is eligible for an independent review, the commissioner shall:

(a) assign an independent review organization from the list of approved independent review organizations;

(b) notify the carrier of the assignment and that the carrier shall within five business days, one business day for an expedited review, provide to the assigned independent review organization the documents and any information considered in making the adverse benefit determination; and

(c) notify the claimant that the request has been accepted and that the claimant may within five business days, one business day for an expedited review, submit additional information to the independent review organization. The independent review organization shall forward to the carrier within one business day of receipt any information submitted by the claimant.

(4) Within one business day after receipt of the request, the independent review organization shall select one or more clinical reviewers to conduct the review.

(5) The clinical reviewer shall provide to the independent review organization a written opinion within 20 calendar days, five calendar days for an expedited review, after being selected.

(6) The independent review organization shall make a decision based on the clinical reviewer's opinion within 20 calendar days, 48 hours for an expedited review, of receiving the opinion and shall notify:

(a) the claimant;

(b) the carrier; and

(c) the commissioner.

(7) Within one business day of receipt of notice that an adverse benefit determination has been overturned, the carrier shall:

(a) approve the coverage that was the subject of the adverse benefit determination; and

(b) process any benefit that is due.

R590-261-13. Disclosure Requirements.

(1) Each carrier shall include a description of the independent review procedure in or attached to the policy and certificate, and may include a description with other evidence of coverage provided to the insured.

(2) The description required in Subsection (1) shall include a statement that informs the insured:

(a) of the right to file a request for an independent review of a final adverse benefit determination and include the contact information for the commissioner; and

(b) that an authorization to obtain medical records shall be required for the purpose of reaching a decision.

R590-261-14. Records.

(1) An independent review organization shall maintain a written record of each independent review for the current year plus 5 years.

(2) The records of an independent review organization shall be available for review by the commissioner upon request.

R590-261-15. Penalties.

A person found to be in violation of this rule shall be subject to penalties as provided under Section 31A-2-308.

R590-261-16. Enforcement Date.

The commissioner shall begin enforcing the revised provisions of this rule on the effective date.

R590-261-17. Severability.

If any provision of this rule or its application to any person or situation is held to be invalid, that invalidity shall not affect any other provision or application of this rule which

can be given effect without the invalid provision or application, and to this end the provisions of this rule are declared to be severable.

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